Instructions for the DIMA 2004 ACRP Season

Contents

Instructions to MedicareAdvantage Organizations for the DIMA 2004 ACRP Season

BACKGROUND AND SCHEDULE

The Medicare Prescription Drug, Improvement and Modernization Act (DIMA or the Act) changed Part C of Medicare—the MedicareAdvantage (MA) program. DIMA requires the Centers for Medicare & Medicaid Services (CMS) to revise MA payment rates for contract year (CY) 2004. The new payment rates will be effective March 1, 2004, and they will be retroactive to January 1, 2004.

In order to ensure that MA organizations use the additional funds provided under DIMA for the benefit of Medicare beneficiaries, DIMA establishes a time period in 2004 during which MA organizations must submit to CMS new Adjusted Community Rate Proposals (ACRPs) for CY 2004. Under DIMA, ACRP re-submissions are required from all M organizations with CMS-approved MA plans for CY 2004. The detailed requirements for transmitting and supporting an ACRP in the CY 2004 DIMA season are outlined below.

The DIMA 2004 Process for CY 2004 ACRPs

The process for the CY 2004 DIMA season ACRPs will be similar to the process for CY 2004 that began in September 2003. This document covers the new features affecting ACRPs. MA organizations will have less time to prepare DIMA season ACRPs and CMS will have less time to review them than for the ACRPs submitted in 2003. Note that ACRPs submitted under the Act are due on January 30, 2004.

WHAT'S NEW FOR THE CY 2004 DIMA ACRP SEASON?

- DIMA increased MedicareAdvantage payment rates for 2004.
- DIMA requires MA organizations to resubmit approved ACRPs for 2004 and specifies the ways in which revised ACRPs can reflect the higher DIMA payment rates.
- DIMA allows MA organizations to offer "exclusive' Medicare drug discount cards in 2004.
- DIMA temporarily suspends limits on MA plan contributions to a stabilization fund.

- DIMA suspends Medicare limits on physical therapy and speech pathology benefits for the remainder of CY 2003 and all of CY 2004 and CY 2005.

- DIMA allows certain private fee-for-service (PFFS) plans to charge a higher co-payment for services received out of network.

- CMS has modified ACRs to handle the changes in payment rates, the administrative costs of enrollment for exclusive discount drug cards, and the suspension of limits on plan contributions to stabilization funds.

- CMS will ask MA organizations to provide information about Medicare discount drug cards when they upload DIMA-related ACRPs.

KEY DATES RELATED TO CY 2004 DIMA ACRPS

The following table shows key dates related to the DIMA 2004 ACRP season.

The President signed the Act	December 8, 2003
CMS releases new payment rates	January 16, 2004
CMS makes HPMS available for upload of ACRPs	January 26, 2004
MA organizations should notify CMS of intent to reenter MA program or to reenter CY 2003 service area	January 23, 2004
Deadline for MA organizations to submit ACRPs to CMS	January 30, 2004
Deadline for MA organizations to submit marketing materials to CMS's regional offices (ROs)	January 30, 2004
Earliest date MA organizations can begin marketing the revised 2004 plan	January 30, 2004
CMS Regional Office complete approval of marketing materials	February 13, 2004
CMS completes review & approval of ACRPs	February 17, 2004
Deadline for MA organizations to notify members of plan changes	March 9, 2004

General Guidance for Submitting ACRPs

The detailed instructions for completing an ACR are available on CMS's web site at www.cms.hhs.gov/healthplans/acr/. However, CMS has not fully updated those instructions for the DIMA 2004 ACRP season. Refer to this document (and supplementary questions and answers on CMS's web site) for the most recent information (e.g., deadlines, suspension of limits on stabilization fund contributions) on the DIMA 2004 ACRP season. More detailed information on the PBP can be found at the Health Plan Management System (HPMS) web site.

MA organizations must submit both paper and electronic documents to fulfil the requirements of the CY 2004 DIMA ACRP process. Both electronic and paper copies of the ACR are required. Only electronic copies of the PBP are required.

Paper copies of ACRs must be postmarked by January 30. The electronic version of ACRs and PBPs must be uploaded to HPMS by midnight, EST, January 30, 2004.

Organizations returning to the MA program need to obtain a copy of the ACR and PBP software necessary to submit their ACRP. Those software tools can be obtained from the HPMS web site. Instructions on how to download and install the ACR and PBP software for CY 2004 are available on CMS's web site and HPMS. Organizations that currently have a 2004 MA contract can use the PBP(s) currently residing on their computer desktops. HPMS will be available for uploads of all ACRPs submitted under the Act beginning on January 26, 2004.

The Act defines three separate situations under which MA organizations will participate in the DIMA 2004 ACRP process. Sections 1, 2, and 3 below discuss those situations.

The remainder of this section discusses selected matters relating to all ACRPs for the DIMA 2004 season.

USE EXISTING VERSION OF THE PBP

The electronic version of the PBP for the DIMA 2004 season is unchanged from the previous version.

USE NEW VERSION OF THE ACR

CMS will be updating the electronic ACR spreadsheets to take into account the changes that the Act has made to the MA program rules. In addition, Part III of Worksheet A will reflect the actual Part B premium for 2004. The new electronic ACR spreadsheets will be available January 20, 2004. Additional instructions for completing ACR Worksheet A1 (Service Area and Estimate of the Average Payment Rate) will be available at that time too. For help with problems completing an ACR electronic worksheet, contact LMI at 703-917-7236.

USE NEW VERSION OF ACRP VALIDATION TOOL

CMS provides a computerized tool (APV Tool) that MA organizations must use to validate their ACRPs. The purpose of the validation process is to catch errors in the electronic versions of ACRs and PBPs before users upload those files to HPMS. Eliminating errors both prevents upload problems and speeds CMS's ACRP review process. Please download the latest version of the APV tool from HPMS.

STABILIZATION FUND LIMITATIONS SUSPENDED TEMPORARILY

The Act has suspended temporarily some previously existing limitations on contributions to stabilization funds. The suspension of the limits will give MA organizations more flexibility to assign part of the payment increase under DIMA to a stabilization fund. The current version of the ACR (V2004.1) limits contributions to the benefit stabilization fund; the new version for DIMA-related ACRPs will not.

NOTE: Effective January 1, 2006, all monies in stabilization funds will be forfeited to the Medicare Trust Funds. All MA organizations must keep this fact in mind when deciding whether or not to add the DIMA 2004 monies to a stabilization fund.

During the 2004 DIMA ACR season, CMS has the authority to allow MA organizations to take any monies out of their stabilization funds to use them as part of the DIMA resubmission during the DIMA season. Therefore, if an MA organization has a balance remaining in its stabilization fund, we advise it to consider this option to prevent any monies from being forfeited to the Medicare Trust Funds. If an organization chooses to use stabilization monies for part of the DIMA resubmission, keep in mind that those monies must only be used to provide additional benefits to members.

As stated above, the DIMA allows CMS to suspend Trust Fund rules only during DIMA 2004 ACR season. Therefore, if an organization chooses to use a stabilization fund during the 2004 DIMA ACR season, it will only be able to make withdrawals from that fund through 2005. As of January 1, 2006, any funds remaining in that stabilization fund will be forfeited to the Medicare Trust Funds.

NEW PAYMENT RATES INCLUDED IN ACR WORKSHEET A1

Worksheet A1 of the ACR spreadsheets will be pre-populated with the new, higher payment rates CMS will calculate under the Act. However, the effect of the new payment rates in January and February 2004 (catch up) must be included as an adjustment on Worksheet A1. DIMA [section 211(i)(3)(B)] requires CMS to pay MA organizations the higher DIMA rate as if it were in effect for the full twelve months of 2004. What this means is that the new APR for March through December must be manually increased to take account of catch-up payments that

CMS will make via retroactive payments for January and February 2004. Note that MA organizations re-entering the program through submissions under Sections 2 or 3 (below) will not make such an adjustment for their *new* plans, as no retroactive payment will be due them for January and February. CMS will develop a methodology for calculating the amount of the catch-up payments. CMS will describe that methodology in the forthcoming supplemental instructions for completing ACR Worksheet A1. As discussed above, CMS will make that supplement available to MA organizations around January 19, 2004.

Administrative Costs of Enrollment in Exclusive Medicare Drug Discount Cards

Section 7 discusses these administrative costs in the context of the DIMA-related 2004 ACRs.

Important HPMS Information

Users can access HPMS on the Medicare Data Communications Network (MDCN) at http://32.82.208.82. CMS requires that MA organizations use a CMS user ID and password to access HPMS. Please contact Don Freeburger at either 410-786-4586 or dfreeburger@cms.hhs.gov with questions on CMS user IDs and passwords.

CMS *strongly encourages* MA organizations that choose to return to the MedicareAdvantage program to contact Don Freeburger as quickly as possible to determine whether their organization has maintained connectivity to the HPMS.

Location of all Important ACR, PBP, and Marketing Materials

Detailed instructions on the ACR, PBP, and marketing materials are available on CMS's web site at www.cms.hhs.gov/healthplans/acr/ . Questions and answers on the DIMA 2004 season are also available there.

CMS Suspends Review of Outstanding ACRPs

Certain MA organizations have outstanding:

- MA applications,
- applications to expand their service area,
- new mid-year plan submissions,
- mid-year benefit enhancement proposals, and
- other proposed corrections to existing MA plans.

In order to ensure the success of the DIMA CY 2004 ACRP process, CMS must suspend review of outstanding ACRP submissions resident in HPMS. Where possible, CMS will work with MA organizations to complete outstanding ACRP submissions prior to the start of the DIMA process. However, if an ACRP submission remains outstanding as of January 9, 2004, CMS will work with the MA organization to determine whether those changes can be incorporated into the DIMA ACRP submission. If your organization needs guidance on an outstanding ACRP submission, please contact Yasmin Galvez at ygalvez@cms.hhs.gov or (410) 786-0434 to discuss the options.

In addition, as of the date of this memorandum, CMS will not accept new mid-year benefit enhancement proposals or new mid-year plan proposals until March 1, 2004.

Medicare Personal Plan Finder Updates

CMS will continue to update the Medicare Personal Plan Finder (MPPF) on a monthly basis. MA organizations will be able to preview their data on HPMS on February 24 and 25. Changes made to the PBP during the DIMA 2004 season will be updated in MPPF on March 4, 2004.

SECTION 1–MA ORGANIZATIONS WITH APPROVED CY 2004 MA PLANS

Under the Act, MA organizations with any CMS-approved CY 2004 MA plans *must* resubmit, by January 30, 2004, the ACRP for those plans. CMS expects all payment rates to increase in all service areas.

In such mandatory resubmissions, MA organizations can make the following DIMA-related changes.

- Reduce beneficiary premiums
- Reduce beneficiary cost sharing
- Enhance benefits
- Contribute to a benefit stabilization fund
- Stabilize or enhance beneficiary access to providers.

In addition, MA organizations can make the following changes not related to DIMA.

- Update 2004 cost projections in Worksheet D (Expected Cost and Variation─Standard Benefit Package) to reflect effects from matters such as "run-out" of base period costs

- Update demographic and enrollment projections used to calculate the average payment rate.

- Correct errors in previously approved ACRP(s)

On the other hand, in such mandatory resubmissions MA organizations cannot:

- Increase beneficiary premiums

- Increase beneficiary cost sharing (except as part of a benefit enhancement where the ACR value of increased cost sharing does not exceed the ACR value of the increase to the benefit)

- Reduce benefits

- Make any changes to the values in the approved ACR Worksheet B (Base Period Costs and Enrollment) or Worksheet B-1 (Financial Data) or to the non-Medicare base period costs on Worksheet A (Cover Sheet), lines 1-6, column a, Part IB

- Increase administrative costs unless the increase has a significant and direct relationship to stabilizing or enhancing beneficiary access to providers or is directly related to enhanced benefits

- Increase additional revenue unless the increase directly relates to enhanced benefits.

Please observe the following for ACRPs submitted under this section.

1. If you are submitting an ACRP under this section, you need to substantiate *all changes* from the most recent CMS-approved CY 2004 ACR for the plan. For example, assume that the approved ACR for your plan had two co-pays. Previous instructions (and this instruction) require you to document ACR values for co-pays. You are reducing one co-pay in January 2004, but the other will not change. Therefore, you should document the *change* to the ACR value of the reduced co-pay. In contrast, you don't have to provide any justification for the ACR value of the unchanged co-pay beyond what you submitted for your previously approved CY 2004 ACR. Please ensure that the materials supporting DIMA-related changes in your ACR(s) are separate from other material supporting corrections to your previous ACR

2. ACRPs submitted under Section 1 should assume DIMA rates and benefits as if effective for all 12 months of 2004. However, the amounts entered will only be used for March 1, 2004 to December 31, 2004. Therefore, please ensure

that your ACRP does not include data on premiums, cost sharing, and other matters related to January and February 2004. For example, the premium on Worksheet C (Premiums & Cost Sharing for Standard Benefit Package) of the ACR and the premium reported in the corresponding PBP should be identical. In addition, calculate the average payment rate (APR) reported on Worksheet A1 using only the new, higher rates under DIMA (including an adjustment for the catch-up payments for January and February 2004). Additional changes should be made to Worksheets A (Cover Sheet), C, and D pursuant to DIMA (e.g., reducing premiums or cost sharing, placing money in the stabilization fund).

3. When submitting an ACR under Section 1, MA organizations have the option to update direct medical cost assumptions and projections previously reported in CMS-approved ACRs for CY 2004 *to the extent these additional costs would help to stabilize or enhance the MA organization's provider network*. This update to direct medical costs could include revised utilization, unit costs, demographic, enrollment, and trend assumptions. Trend assumptions could be changed by adjusting the initial rate in Worksheet A (i.e., the contract period data in Part IB, column b, lines 1-6). Note that additional revenues in DIMA-related ACRs cannot be greater than the corresponding amounts in your previous, CMS-approved ACR unless the increase is directly related to enhanced benefits in the revised PBP. In addition, administration costs for a revised ACR cannot be greater than the corresponding amounts in your previous, CMS-approved ACR unless the increase has a significant direct relationship to stabilizing or enhancing beneficiary access to providers or enhanced benefits in the revised PBP. Document such changes to administrative costs and additional revenue in your ACR back-up material. To expedite the review of revised ACRPs, a cover letter should accompany the hard copy submission of the ACR. MA organizations must include the previously approved average payment rate (APR), the new APR (using the higher rates calculated under DIMA only), and a list detailing how your plan will use the increased payment and displaying the share (expressed as a percentage or as a dollar amount) in each of the five DIMA categories (e.g., reduce beneficiary premiums, reduce beneficiary cost sharing, enhance benefits) listed on page 9. The total for all five categories should not exceed the total amount of the increased payment under DIMA. If you are using your increased payment to stabilize or enhance enrollees' access to providers, including costs associated with higher unit costs and utilization, explain how each change stabilizes and/or enhances access to providers.

   After the BIPA payment increase and ACR resubmissions in 2001, audits conducted by the Office of the Inspector General (OIG) of those resubmitted ACRs established that documentation related to network enhancements was *insufficient*, in many cases, to establish that the MA organization's extra CMS payments were actually spent on stabilizing or enhancing provider networks. Therefore, CMS reviewers will be checking the information in your cover letter that explains the use of DIMA-related payments to enhance and

stabilize your provider network. Your careful attention to the cover letter requirements will facilitate that check. In addition, please retain all documents needed to support your explanation and be prepared to make them available to CMS and/or OIG auditors. Audits of DIMA-related ACRPs will focus on verifying the explanation of network enhancements provided with DIMA-related ACRPs. We recognize that the MA organizations may want more guidance on what OIG considers to be acceptable documentation. CMS is consulting with the OIG on this issue and will provide more information at a later date.

In addition, if there are any corrections that you wish to make to your approved ACRP, and if CMS has granted your MA organization approval to make such corrections, mention these items in the cover letter. Resolutions of issues during the prior desk review process and any other information the MA organization wishes to make CMS aware of concerning the resubmission of the ACR under DIMA should also be included.

4. MA organizations should revise their PBPs at the local level using the PBP 2004 software.

5. MA organizations should update their most recent CMS-approved ACR for upload to HPMS in January 2004. The correct version of the ACR will be V2004.2

6. MA organizations will upload their revised ACRs and PBPs to the HPMS as a mid-year benefit enhancement transaction. Please refer to the 2004 ACRP User's Manual available on www.cms.hhs.gov/healthplans/acr/ and the HPMS for the complete set of pre-upload requirements and upload instructions.

7. MA organizations must mail the required reduced paper substantiation (i.e., hardcopy of the ACR with certified signatures and supporting documentation referencing only the changes) to LMI. Also, please refer to Section 5 for details on assembling and packaging your paper material for shipment to LMI.

SECTION 2–MA ORGANIZATIONS WITH APPROVED CY 2004 MA PLANS RE-ENTERING A PREVIOUSLY REDUCED SERVICE AREA

MA organizations with approved CY 2004 MA plans that are re-entering a previously reduced service area can restore all or part of their previous service area during the DIMA 2004 ACRP season.

One of the requirements to restore your CY 2003 service area is to submit an ACRP to CMS by January 30, 2004. Another is to provide CMS with separate, written notification of your intent to restore all or part of your CY 2003 service area. The following procedures relate to such ACRPs and notices.

1. MA organizations must send CMS written notification of intent to re-enter all or part of their CY 2003 service area, non-renewed for January 1, 2004, using a model letter. Because ACRs are due January 30, MA organizations are strongly encouraged to submit this letter by January 23, 2004. The model letter is in Attachment 2. This letter must also include a Certification of Network Adequacy (Attachment 3).

   The letter must be sent to the attention of:

   Ms. Cynthia Moreno
   c/o Ms. Rosanna Johnson
   Health Plans Benefit Group
   Center for Beneficiary Choices
   Centers for Medicare & Medicaid Services
   7500 Security Boulevard, Mail stop: C4-23-07
   Baltimore, MD 21244-1850

   A copy of this letter should be sent to the plan managers at the CMS Central Office and the lead Regional Office. Due to the timeliness of this matter, we encourage you to submit your letter and certification via fax at (410) 786-8933 as soon as possible, and then send the original copy by mail.

2. Upon receipt of your notice of intent to re-enter all or part of the previously non-renewed CY 2003 service area, CMS will take the appropriate actions in the HPMS to restore the service area.

3. MA organizations must create one or more new plans to cover the newly available county or set of counties and download the new ACR(s) and PBP(s) via the HPMS. *If the written notification identified in #1 is not received in a timely manner, the process of creating plans and downloading the ACR(s) and PBP(s) will be prohibited until CMS receives such notice, which may reduce the time that the MA organization has to complete its ACR(s) and PBP(s).*

4. Organizations must complete an ACR and a PBP for each new plan (using the new mid-year plan option in HPMS). You can copy benefit packages between plans within the PBP 2004 software using the "Copy Plan" function on the PBP Management Screen. You can also make a copy of an ACR spreadsheet and make the necessary adjustments for use with another plan.

5. MA organizations will upload their ACRs and PBPs to the HPMS as a new mid-year plan transaction. Please refer to the *2004 ACRP User's Manual* available on www.cms.hhs.gov/healthplans/acr/ and the HPMS for the complete set of pre-upload requirements and upload instructions.

6. MA organizations must mail the required full set of paper substantiation (i.e., hardcopy of the ACR with certified signatures and complete set of supporting documentation) to LMI. See Section 4 below for a list of the ACR items need-

ing substantiation. Also, please refer to Section 5 for details on assembling and packaging your paper material for shipment to LMI.

7. MA organizations submitting ACRPs under Section 2 will be required to agree to amend their contracts at Attachment D to include the new counties. CMS will send each MA organization re-entering a previously reduced service area a contract modification agreement. It must be signed and returned to CMS prior to the effective date.

8. ACRPs submitted under Section 2 must cover the specific period of performance in the related MA contract.

SECTION 3–MA ORGANIZATIONS THAT ARE RETURNING TO THE MA PROGRAM FOR CY 2004

MA Organizations that withdrew from the MA program for CY 2004 can re-enter the MA program during the DIMA 2004 ACRP season. One of the requirements to do so is to submit an ACRP (or ACRPs) to CMS by January 30, 2004. Another is to notify CMS separately, in writing, of your intent to do so. The following procedures relate to such ACRPs and notices.

1. MA organizations must submit to CMS written notification of intent to return to the MA program for CY 2004 using a model letter. Because ACRs are due January 30, MA organizations are strongly encouraged to submit this letter by January 23, 2004. The model letter is in Attachment 2. This letter must also include a Certification of Network Adequacy (Attachment 3).

   The letter must be sent to the attention of:

   Ms. Cynthia Moreno
   c/o Ms. Rosanna Johnson
   Health Plans Benefit Group
   Center for Beneficiary Choices
   Centers for Medicare & Medicaid Services
   7500 Security Boulevard, Mail stop: C4-23-07
   Baltimore, MD 21244-1850

   A copy of this letter should be sent to the plan managers at the CMS Central Office and the lead Regional Office. Due to the timeliness of this matter, we encourage you to submit your letter and certification via fax at (410) 786-8933 as soon as possible, and then send the original copy by mail.

2. Upon receipt of your notice of intent to return to the MA program for CY 2004, CMS will take the appropriate actions in the HPMS to restore the H number and service area.

3. MA organizations must create one or more new plans and download the new ACR(s) and PBP(s) via HPMS. *If the written notification identified in #1 is not received in a timely manner, the process of creating plans and downloading the ACR(s) and PBP(s) will be prohibited until CMS receives such notice, which may reduce the time the MA organization has to complete its ACR(s) and PBP(s).*

4. MA organizations must complete an ACR and a PBP for each new plan. You can copy benefit packages between plans within the PBP 2004 software using the "Copy Plan" function on the PBP management screen. Also, you can make a copy of an ACR spreadsheet and make the necessary adjustments to use it with another plan.

5. MA organizations will upload their ACRs and PBPs to the HPMS as a renewal transaction. Please refer to the 2004 ACRP User's Manual available on www.cms.hhs.gov/healthplans/acr/ and the HPMS for the complete set of pre-upload requirements and upload instructions.

6. MA organizations must mail the required full set of paper substantiation (i.e., hardcopy of the ACR with signatures on Worksheet A and a complete set of supporting documentation) to LMI. See Section 4 below for a list of the ACR items needing substantiation. Also, please refer to Section 5 for details on assembling and packaging your paper material for shipment to LMI.

7. MA organizations submitting ACRPs under Section 3 must sign new MA contracts. CMS will mail the new contracts, which will reflect any new program requirements created by the Act, after receiving the notice of intent to re-enter the MA program. Re-entering MA organizations must return their 2004 contracts to CMS prior to the effective date.

8. ACRPs submitted under Section 3 must cover the specific period of performance in the related MA contract.

NOTE: MA organizations that withdrew from the MA program prior to January 1, 2004, cannot submit ACRPs for new plans in the CY 2004 DIMA season. Such organizations can, however, apply to return to the program.

SECTION 4–SUBSTANTIATION REQUIREMENTS FOR ACRS SUBMITTED UNDER THE ACT

This section describes ACR worksheet items that require substantiation documentation. As explained above, the substantiation of required items for ACRs submitted under Section 1 must relate to the *changes* from your currently approved ACR. On the other hand, substantiation for ACRs submitted under Section 2 or Section 3 (which will be original submission, not resubmission) must cover all ACR entries.

The following sections discuss the most common needs for supporting justification of ACR matters. However, the ACR Instructions and other sections of these instructions describe other types of supporting documentation needed in special circumstances. For resubmissions under Section 1 of this document, please separate the back-up for DIMA-related changes from the back-up for any changes not related to DIMA. For resubmissions under Sections 2 and 3 of this document, please refer to the *How to Transmit and Support your ACR for Contract Year 2004* on the CMS web site (www.cms.hhs.gov/healthplans/acr/) for additional information about the cover letter and other matters.

Calculation of Limit of Discount Card Enrollment Fee. **If your plan will offer a Medicare discount card, if you entered a value on line 25ev2 of Worksheet D, *and* if you are charging an additional enrollment fee for the card, please include your calculation of the plan's limit on the annual enrollment fee. Be sure to show the number of enrollees that you expect to elect the card. See Section 7 for information about the discount card.**

Worksheet A (Cover Sheet). Please provide the following supporting documentation:

- **Initial rate components**—**A-1**. Refer to Worksheet A, Part IB, column b, line 1 through line 6. MA organizations that use a community rating method to determine their initial rate also must submit the weighted average of all premiums and cost sharing charged to non-Medicare enrollees. (See Chapter 2 of the ACR Instructions for an explanation of these terms.) Please provide substantiation for all initial rate calculations. If the total premium from a weighted average of premiums and cost sharing is less than the initial rate calculated under the community rating methodology, you must provide adequate supporting documentation for the difference. If the plan has no initial rate, indicate why not. Please put this material in a section labeled "**A-1**."

- **Actuarial Certification**—**A-2**. If you submit an actuarial certification as discussed in Chapter 2 of the ACR Instructions, please label it "**A-2**."

- **Withdrawals from a stabilization fund**—**A-3**. Refer to Part IA, line 9. Indicate which conditions in 42 CFR 422.312 the plan has met if it proposes to make withdrawals from a stabilization fund. Please put this material in a section labeled "**A-3**."

Worksheet A1 (Service Area and Estimate of Annual Payment Rate)—**A1-1**. As discussed in Chapter 3 of the ACR Instructions, if you use your own risk factors, (in column j of Worksheet A1) instead of risk factors CMS provided to your organization, explain your method for calculating them. Please provide all calculations and assumptions.

In addition, justify all adjustments shown in column t of Worksheet A1. Please provide all calculations and assumptions.

***Worksheet B (Base-Period Costs per Member-Month)*—B-1**.

The base-period data entered on Worksheet B should vary depending on the nature of the transition of a plan between the base period and the contract period. Please see the 2004 call letter for more information on which base period data to include on Worksheet B. Please indicate the CY 2002 plan ID(s) from which the base period data was obtained.

As in prior years, MA organizations will be permitted to group data in the health care components (lines 1-19) on Worksheet B of the ACR. However, grouping methods used in prior years will not necessarily be acceptable in 2004, especially methods that group all cost data on one line. CMS is requiring MA organizations to use as many health care components as possible. Please see the CY 2004 call letter (www.cms.hhs.gov/healthplans/acr/) for more information.

Prior approval of the grouping methodology is not required. However, MA organizations must include a detailed description of the grouping method used. Please show the 19 health care components included in the ACR and the corresponding line on which that cost data would be entered. For example, if costs for dental services (line 16) are consolidated with the costs for preventive services (line 14), then include the following:

ACR Categories	MA organization's Categorization
16. Dental	14. Preventive Services

If you are reporting Optional Supplemental Benefits on Worksheet B, please show, in your ACR backup material, the base-period amounts for direct medical costs without reinsurance recoveries, administration costs, reinsurance premiums, and additional revenues for each individual Optional Supplemental Benefit. Show each of those four items separately. Please provide detailed calculations supporting your estimates in the backup material for your ACR. In addition, break out the expected receipts for COB–Other allocated to each benefit.

***Worksheet B1 (Base Period Financial Data)*—B1-1**. If the values reflected on this spreadsheet cannot be readily traced to the organization's audited financial statements, please submit an explanation. It should explain clearly the reasons for any deviation from the audited financial statements.

***Worksheet C (Premiums and Cost Sharing for the Standard Benefit Package)*—C-1**. Use section C-1 to show clearly the methodology you used to project each of the values reflected in columns a through f for all the components of lines 1 through 21. Be sure to identify the amount of each out-of-pocket cost-sharing charge and any other values (e.g., utilization rate) used to estimate each ACR value. In addition, if you use waivers under section 617 of BIPA, remember to

retain in your files the backup materials discussed in section 130 of Chapter 8 of the *Medicare Managed Care Manual*.

For lines with multiple benefit service categories in the PBP, the substantiation must reflect a corresponding level of detail. For example, if a plan has a $5 co-pay for primary care physician services and a $10 co-pay for physician specialist services (lines 7a and 7d in the PBP), then the substantiation must reflect the methodology used to calculate the per-member, per-month value of each of those cost-sharing arrangements.

Worksheet C1—Part B-Only Maximum Charge for Part A Benefits. No substantiation is necessary. Worksheet C1 is required just for Part B-only plans.

***Worksheet D (Expected Cost and Variation for the Standard Benefit Package)*—D-1**. Show in section D-1 the rationale for each expected variation entry on the spreadsheet (except for negative entries on line 27ev2). Any justification provided should be in enough detail to fully explain the specific expected variation at issue.

Some justifications can be very brief. For example, merely stating that you made an entry to eliminate the costs in the worksheet for a previously offered benefit that you will not offer in the contract year would be adequate justification. However, other justifications—such as one pertaining to the costs of a new benefit, to any positive entry on line 27 of Worksheet D, or to MA benefits where the 2-year growth rate for costs differs from the 2-year trend for non-Medicare direct medical costs (from Worksheet A)—need to be more detailed and must include **all** computations.

In addition, if you use waivers under section 617 of BIPA, remember to retain in your files the backup materials discussed in section 130 of Chapter 8 of the *Medicare Managed Care Manual*. Finally, refer to Chapter 8 of the ACR Instructions for more details on justifying expected variation entries.

IMPORTANT: For ACRPs resubmitted under Section 1, please explain how any increases in additional revenue relate to enhanced benefits in a revised PBP. In addition, please explain how any increases in administration costs have a significant and direct relationship to stabilizing or enhancing beneficiary access to providers or enhanced benefits in a revised PBP.

Worksheet E (Adjusted Community Rate for the Standard Benefit Package). No substantiation is necessary.

***Worksheet F (Adjusted Community Rate, Premiums, and Cost Sharing for Optional Supplemental Benefits)*—F-1**. For entries related to premiums and cost sharing, provide in section F-1 the same substantiation material described in the above discussion of Worksheet C. For expected variation entries, provide in section F-1 the same material described in the above discussion of Worksheet D.

Refer to Chapter 8 of the ACR Instructions for more information on justifying expected variation entries.

If you are reporting Optional Supplemental Benefits on Worksheet F, please show in your ACR backup material, the projected amounts for direct medical costs without reinsurance recoveries, administration costs, reinsurance premiums, and additional revenues allocated to each individual Optional Supplemental Benefit. Show each of those items separately. Please provide detailed calculations supporting your estimates in the backup material for your ACR. In addition, break out the expected receipts for COB–Other allocated to each benefit.

Worksheet G (Actuarial Review Sheet). No substantiation is necessary.

SECTION 5–INSTRUCTIONS FOR PACKAGING AND TRANSMITTING PAPER COPIES OF ACRS AND ACR SUBSTANTIATION

This section applies to all DIMA ACRP submittals and re-submittals in January 2004.

General

The MA organization will transmit a paper copy of the ACR and supporting documentation via U.S. Mail or commercial delivery service to the following address:

LMI
ATTN: ACRP
2000 Corporate Ridge
McLean, VA 22102-7805

The paper copy must be identical to the electronic copy you submit, except that the paper copy will contain the certification signatures required by CMS. For purposes of the DIMA 2004 ACRP season, Worksheet A of each and every MA plan's ACR must have both signatures on the certification. In addition, changes to the certification statement printed on Worksheet A are prohibited.

Paper, Printing and Binding Requirements

CMS will use scanning technology to expedite the processing and review of paper documents. To facilitate such scanning, please adhere to the following paper, printing, and binding requirements. Paper documents that don't meet the following specifications may be returned unprocessed to the MA organization, which means that the organization would have to correct and resubmit the materials to CMS. The following specifications apply to all paper documents such as ACR worksheets, the transmittal letter, and the supporting documents**.**

- paper size: 8 ½ x 11 (letter size only)
- page orientation: landscape (sideways)
- single-sided
- paper color: white only
- hole punching: none
- font size: minimum of 10 point
- font color: black
- graphics or logos: none of any kind
- binding: none, except for binder clips

Again, each package of ACR materials should be unbound or bound with binder clips. Please do not use staples, paper clips, ring binders, rubber bands, or any type of permanent binding material.

ACR Supporting Documentation and Assembly

The ACR workbook is composed of individual Excel worksheets. The printing and binding requirements and the assembly instructions for the paper copy of each ACR workbook and its supporting documentation are shown below. CMS electronically scans your paper submissions to smooth the progress of its ACRP review process. Please follow these instructions carefully to facilitate the scanning.

A tab or placeholder should separate each ACR workbook and its supporting documentation. The number of tabs that an MA organization needs will depend on how many ACR workbooks it files.

To the extent possible, please assign tabs a number that corresponds to the plan ID. For example, Tab 1 would contain the ACR and supporting documents for Plan 001.

Assemble your material in the following order:

- Transmittal form
- Cover letter
- Tab 1 for first plan (Plan 001)
- Substantiation
- Tab 2 for second plan (Plan 002)
- ACR worksheets
- Substantiation
- Tab 3 for next plan, etc., etc.

Packaging

MA organizations are encouraged to send all of their ACRs for the same H-number in the same package.

In addition, each sheet of paper that is submitted must meet the paper, printing, and binding requirements described above to facilitate electronic scanning by CMS.

The MA organization also must make sure that *each ACR workbook and its corresponding supporting documentation is numbered consecutively in the upper* ***left****-hand corner*. Handwritten numbers are fine. The transmittal letter that is attached to all ACR workbooks and substantiation should clearly state the number of pages for each ACR and the total number of all pages (multiple ACRs) submitted. That will allow CMS to verify that all worksheets and supporting documentation paper copies are received.

In addition, each section of *supporting documentation* submitted must contain the appropriate label e.g., **A1-1** in the upper **right**-hand corner of every page. Those labels, which facilitate the indexing of scanned documents, are described on the next page.

Transmittal Form

Attachment 1 is a blank transmittal form. Please fill out one transmittal form to accompany each package of ACRs per CMS "H" number. For example, consider an MA organization with two H numbers and eight plans. It plans to submit three ACRs under contract number H0008 and five ACRs under contract number H0009. Therefore, the MA organization would submit one transmittal form for the three ACRs as a package under H0008 and one transmittal form for five ACRs as a package under H0009.

Please place the transmittal form on top of all the paper copies of the ACRs.

ACR Excel Worksheets – First item of a tab

The ACR workbook contains ten separate spreadsheets. The paper copy of the ACR workbook should be the first item filed under any tab. Submit ten worksheets, even ones that you don't need to use for your ACR (i.e., blank worksheets). The appropriate supporting documentation for that ACR should start with the second item of each tab.

ACR Supporting Documentation – Second item of a tab

The supporting documentation for an ACR worksheet should be the second item filed under any tab; in other words, it should be filed directly behind the ACR worksheets.

The substantiating records for the information reflected on that spreadsheet are subject to audit by CMS in accordance with the Social Security Act. If, during the course of the ACR plan review, it becomes necessary to seek any further substantiation of the data in any worksheet, CMS will ask the MA organization to provide that information separately.

To facilitate the indexing of scanned documents, each page of supporting documentation (NOT ACR worksheets) submitted must contain a label in the upper **right**-hand corner of every page. The label should look like this: A1-1. The letter (and the number preceding the hyphen in the case of Worksheet A1) refers to an ACR worksheet that is being supported. The number after the hyphen refers to a specific item of documentation (see below). Handwritten labels are acceptable.

Do not consolidate supporting documentation in any one section. In other words, put all documents relating to Worksheet A in section A, put all the documents relating to Worksheet A1 in section A1-1, and so forth.

SECTION 6–GENERAL GUIDANCE FOR CHANGING DIMA ACRPS AFTER UPLOAD TO HPMS

This section applies to all ACRPs for the DIMA 2004 ACRP season.

Users can change DIMA ACRPs uploaded to HPMS during the period from January 26, 2004 to January 30, 2004 whenever they wish. However, after midnight EST January 30, 2004, HPMS will control electronic submissions of ACRPs by certified users. At that point, you will have to get CMS approval to change an ACRP (i.e., the electronic ACRP or the paper ACR). That procedure will apply to changes initiated by either MA organizations or CMS.

If your organization wants to initiate a change to its ACRP(s) after January 30, 2004, contact LMI for advice on how to proceed. After you get approval for a resubmission, LMI will arrange for you to access HPMS at the appropriate time.

After you make an approved upload to HPMS with your changes, remember to send LMI revisions of the paper copies that correspond to your changes to the electronic version. Don't forget to include the appropriate certification (i.e., the signatures on Worksheet A). Refer to page 27 of CMS's ACR instructions to determine when the certification on Worksheet A must be completed for a resubmittal. Whenever signatures for the certification are necessary for a specific type of

change in the context of a resubmittal after the due date, please make sure that the certification for each plan affected is signed.

Use the same mailing address and packaging procedures for resubmissions that you used for the initial submission of your ACR.

SECTION 7–"EXCLUSIVE" MEDICARE DISCOUNT CARDS AND THE ACR

DIMA allows MA organizations to offer "exclusive" Medicare discount drug cards as an optional supplemental benefit to members of an MA plan. MA organizations that intend to offer an exclusive discount card must submit a separate application to CMS. You can access the solicitation for Medicare managed care organizations planning to apply for an endorsement of an exclusive card program, at http://cms.hhs.gov/discountdrugs/default.asp. This solicitation also provides more information about the program and due dates for the application. If you do not intend to offer an exclusive Medicare discount card to members of a plan, you can skip this section. Otherwise, you must follow these instructions for DIMA ACRs pertaining to plans in which you intend to offer exclusive Medicare discount cards.

In an upcoming regulation, CMS will identify exclusive Medicare discount cards as a separate kind of MA benefit. We need to do this because the definition of a benefit as it currently exists in the MA regulation does not include benefits for which the MA organization incurs no direct medical expense. (See the definition of benefit in 42 CFR 422.2.) Because MA organizations will not incur a cost for exclusive discount cards other than an administrative cost, CMS needs to define them as a different kind of benefit ─ the exclusive Medicare discount card benefit.

Within this framework, if an MA organization subsidizes the enrollment fee (or offers the drug card for no fee) for drug card eligible members, the MA organization must include the drug card program as an additional benefit under its ACR filing. If an MA organization will charge a fee to eligible Medicare managed care plan members for its drug card, then the benefit would be considered an optional supplemental benefit. This is because MA organizations cannot require members of an MA plan to elect exclusive discount cards as a condition of enrollment in any MA plan. (See Section 105(a)(3) of Title I of DIMA: *Voluntary nature of program*.): "Nothing in this section shall be construed as requiring a discount card eligible individual to enroll in an endorsed discount card program under this section."

To the extent that an MA organization offers an exclusive Medicare discount card to enrollees in a specific MA plan, the MA organization can establish an annual enrollment fee/premium for such card. MA organizations do not have to charge a fee for the card. However, if they do, the fee cannot exceed $30 in any contract year. A lower fee for M plan members might recognize the fact that

compared to the costs of enrolling non-MA beneficiaries in the same card, MA organizations experience a lower administrative burden related to enrolling MA plan members in the discount card program due to their existing relationship with their own members.

No PBP Changes to Reflect the Discount Card

CMS has not incorporated exclusive Medicare discount drug cards into the electronic version of the PBP. However, MA organizations that will offer exclusive Medicare discount cards to enrollees of an MA plan will have to answer specific questions about the card when they upload their DIMA-related ACRPs to HPMS.

ACR Changes to Reflect the Discount Card

CMS will allow MA organizations to include, in the ACR, administrative costs related to any discount card enrollment. Enter such costs (on a per-member, per-month basis ─ PMPM) on line 25ev2 of the Medicare-covered benefits column of Worksheet D. The costs should reflect your estimate of the number of enrollees that will elect the discount card as an optional supplemental benefit. In order for the PMPM value on line 25ev2 to be consistent with other ACR values, please compute it using the total projected plan membership. The entry on line 25ev2 cannot exceed $2.50 PMPM. The addition of line 25ev2 is the only ACR change specifically related to the discount card. Do *not* make any entries relating to the discount card on ACR Worksheet F (Adjusted Community Rate, Premiums, and Cost Sharing for Optional Supplemental Benefits).

Limits on Enrollment Fee for the Discount Card

If you decide to charge plan enrollees an enrollment fee for the discount card, you can charge up to $30 per-card enrollee, per-year *less* the total *annual* amount of administrative costs you expect to incur for the enrollment fee. If you plan to charge an enrollment fee, use the following method for calculating the upper limit on the discount card annual enrollment fee.

1. Calculate the total administrative cost you expect to incur in 2004 for the CY 2004 card enrollment fee.

2. Divide the total annual administrative cost in 2004 related to the enrollment fee by the number of plan enrollees in 2004 that you expect to elect the discount card.

3. Subtract that value from $30. The result is the maximum annual amount your plan can charge plan enrollees for a discount card.

If you have no entries on line 25ev2 of Worksheet D, the limit on the discount card enrollment fee is $30 per card enrollee per year.

SECTION 8–PRIVATE FEE-FOR-SERVICE PLANS

Section 211(j) of Title II of DIMA allows private fee-for-service (PFFS) plans with sufficient providers or health care professionals under contract (for a category of provider or health care professional) to charge members a higher co-payment for services received out-of-network (OON). This provision goes into effect on January 1, 2004.

MA organizations that wish to establish this benefit for their PFFS plans must first obtain approval of the plan's provider network with CMS. The PFFS plan may be a new plan with this new benefit, or it may be a part of the existing PFFS plan.

PFFS plans must submit their request to CMS Central Office with a copy to the appropriate CMS Regional Office. The Central Office Plan Manager and the Regional Office Plan Manager will review the submitted material and make a determination based on the information submitted as part of this proposal. The Central Office Plan Manager will inform the PFFS plan of the decision.

When submitting a formal request, the PFFS plan must submit the following information as part of its proposal:

1. Description of the proposed plan(s), including indication of whether this is a new plan or a change to the existing plan.

2. Explanation of how the contracted provider network(s) will meet access and availability standards.

3. Explanation of what types of providers will serve the plan(s) (e.g., Home Health).

4. Proposed effective date for the new plan (or change to existing plan). Note: If this is a change to an existing plan, keep in mind that all members must receive notice of the change 30 days in advance of the change.

In addition, as part of the formal request, the PFFS plan must complete the:

- Health Services Delivery (HSD) tables as found in the PFFS Application, and

- Provider Contracts and Agreements section of the PFFS Application.

After CMS approves the proposal, the PFFS plan must submit a new (or revised, if applicable) ACR and PBP to CMS. (Note: for organizations that are revising their plans, this revised ACR/PBP is not the same as the revised DIMA ACR/PBP that must be submitted by January 30. This is another revision to the ACR/PBP

that is sent after CMS approved the proposal). The PBP currently does not capture OON services for PFFS plans. As a result, the PFFS plan must include the OON cost sharing in the PBP notes section for each category. PFFS plans that are adding this benefit to the existing plan should treat the ACR/PBP change as a mid-year benefit enhancement (MYBE).

While CMS will not be accepting other MYBEs during the DIMA ACR re-submission season or until March 1 (as discussed in the subsection entitled "CMS Suspends Review of Outstanding ACRPs"), CMS will accept an MYBE from a PFFS plan that includes this benefit change during the DIMA ACR season.

At the same time the ACR/PBP is submitted, the plan must submit to the Regional Office the following marketing materials:

For new plans:

- Provider Directory;
- All Member Correspondence Relating to the Plan;
- SB, including the hardcopy change to Section 1 (see below); and,
- EOC.

For changes to existing plans:

- Letter to all members explaining the change;
- Provider Directory;
- All Member Correspondence Relating to the Plan that changes as a result of this change;
- SB, submit the hardcopy change to Section 1 (see below); and,
- EOC – change pages/addenda only if the EOC is already approved/printed.

Hardcopy Change to the Summary of Benefits: Since the PFFS plan will charge more if a member goes OON, it will be necessary to make a hardcopy change to Section 1 of the PFFS plan SB. In particular:

1. The subsection entitled "CAN I CHOOSE MY DOCTORS" needs to be modified to say the following:

   [Plan name] has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

2. After the section entitled "CAN I CHOOSE MY DOCTORS" you will need to include the following new section:

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you must follow special rules in order for {name of plan} to pay for these services. Otherwise, neither {name of plan} nor the Original Medicare Plan will pay for these services. For more information, please call the number at the end of this introduction.

SECTION 9–INSTRUCTIONS FOR PLAN MARKETING MATERIALS

MODIFYING MARKETING MATERIALS TO SAY "MEDICARE ADVANTAGE" INSTEAD OF "MEDICARE+CHOICE"

Section 201(c) of the DIMA automatically changed the name of M+C organizations from "Medicare+Choice" to "Medicare Advantage." Both CMS and MA organizations have to use the term "Medicare Advantage" in all publications and marketing materials no later than with materials referencing the calendar year 2006 plans.

We will provide more guidance under separate cover regarding the transition of marketing materials from "M+C" to "Medicare Advantage." Our goal is to have the transition occur at about the same time both for CMS and for all M+C organizations. However, any M+C organization has the legal authority to modify its marketing materials immediately, if it chooses to do so.

NOTIFICATION TO MEMBERS OF DIMA PLAN CHANGES

Section 211(h)(4) of DIMA requires all M+C organizations to notify members of any plan benefit and/or cost sharing changes made as a result of the new payment rates no later than 3 weeks after CMS approval of the ACRP. Since the new rates and changes in plan benefits go into effect on March 1, we will update the Medicare Personal Plan Finder with this information on March 4, 2004. We encourage you to also try and provide notice to your members by March 4, 2004. However, all members must be notified no later than March 9, 2004.

The earliest date that an MA organization can begin marketing the revised 2004 plan is January 30, 2004, after it has submitted the ACR/PBP and received approval of the marketing materials from the CMS Regional Office. On the date that the organization begins marketing the revised 2004 plan, it must cease marketing the "old" 2004 plan through public media.

To expedite the review process and enable MA organization to meet this date, we will follow a streamlined marketing review process. This process is generally

outlined in Chapter 3 of the Medicare Managed Care Manual, section 20.4, although some modifications are necessary as outlined below. MA organizations are strongly encouraged to ensure that any proposed benefits/cost sharing contained in the marketing materials are accurate. Any mistakes or changes to benefits/cost sharing will result in an organization having to send errata sheets to its membership.

MA organizations submitting ACRPs under Sections 2 or 3 (i.e., re-entering a previously reduced service area or returning to the MA program):

These MA organizations must prepare a new SB for prospective enrollees. An Annual Notice of Change (ANOC) is not required. The MA organization must submit Sections 1 and 3 of a standardized Summary of Benefits (SB) to the appropriate CMS Regional Office no later than January 30, for review and approval prior to dissemination. The MA organization may also submit Section 2 of the PBP, if it wants to have the Regional Office review the SB against the submitted PBP. The SB must describe the proposed benefits offered by the MA organization for each particular plan based on the standardized format, as produced from each PBP. The SB must include the prominent disclaimer that the benefits are "pending Federal approval."

If an MA organization chooses to send the new SB to its former Medicare members, it must include a cover letter explaining that the MA organization has decided to return to the MA program (or re-enter a previously reduced service area). The letter must be reviewed and approved by CMS prior to dissemination. Use of a model letter (Attachments 4 and 5) will expedite the review.

If your ACRP is approved before you have begun printing your materials, remove the disclaimer before printing (no additional RO review is necessary for this minor change). If you have already printed and/or mailed materials after your ACRP is approved, remove the disclaimer the next time the materials go to print.

MA organizations with approved CY 2004 MA plans:

These MA organizations must resubmit CY 2004 ACRPs for all such plans by January 30, 2004 (see Section 1). To the extent that these revised ACRPs result in changes to the benefits currently scheduled to be offered in 2004, each organization must send a letter to its current Medicare members that describes the specific proposed benefit changes for CY 2004. Use of a model letter (attached) will expedite the review.

The MA organization must also update its CY 2004 marketing materials (via an errata sheet or addendum) to reflect the new benefits.

Both the member letter and any errata sheet or addendum must be submitted to the appropriate Regional Office no later than January 30 for review and approval prior to dissemination. The materials must include the prominent disclaimer that the benefits are "pending Federal approval." When submitting the letter and other

materials to the Regional Office for prior approval, the materials may be in template format (leaving space for the MA organization to insert the description of proposed benefits) or they may already contain the proposed benefits for the Regional Office to review against the submitted PBP. The new benefits described in these materials must accurately reflect the revised PBP that is submitted in the ACRP for each particular plan.

If your ACRP is approved before you have begun printing your materials, remove the disclaimer before printing (no additional RO review is necessary for this minor change). If you have already printed and/or mailed materials after your ACRP is approved, remove the disclaimer the next time the materials go to print.

NOTIFICATION TO MEMBERS ABOUT CHANGES IN MEDICARE COVERAGE

DIMA includes several changes in Medicare coverage that go into effect either upon enactment or on January 1, 2004. Generally, regulations require MA organizations and Medicare Cost Plans to notify their members of changes in plan benefits at least 30 days in advance of the effective date of the changes. To the extent that it is not possible to provide that advance notice (i.e., in the case of the benefits going into effect on December 8, 2003 or January 1, 2004), CMS will not take any enforcement actions against an organization based on a failure to comply with the 30-day advance notice requirement. However, the organization must still provide notice of these new benefits to all members. Therefore, we are requiring all MA organizations and Medicare Cost Plans to notify members of these changes in Medicare coverage no later than March 9, 2004.

There is one exception to the requirement that all members must be notified by March 8, 2004. In the event an MAorganization or Medicare Cost Plan has no plan benefit changes to communicate to members and did not ever apply the PT/OT/SP therapy cap described below (i.e., the DIMA provision does not result in a change to plan benefits), then we will not require the organization to send a separate letter to all members announcing the remaining two Medicare coverage changes. Instead, these organizations can mention those two benefits in a cover letter (or insert) to the EOC that they will be sending to all members by April 1, 2004.

The immediate changes to Medicare coverage and their citations in the legislation are outlined below.

Section	Provision/Explanation	Effective Date
Title IV, 624	Suspension of financial limits on incurred expenses for Physical/Occupational/Speech Pathology Therapy services - suspended for the remainder of 2003 and for all of 2004 and 2005.	December 8, 2003

Title IV, 642	Intravenous Immune Globulin (IVIG) for treatment of primary immune deficiency diseases in the home: Medicare will pay for IVIG for the treatment of primary immune deficiency diseases in the beneficiary's place of residence.	January 1, 2004
Title IV, 706	Coverage of religious non-medical health care institution (RNHCI) services furnished in the home: The provision expands coverage under Medicare to include RNHCI services when furnished in the home, but only with respect to items and services ordinarily furnished by home health agencies that are not RNHCIs.	December 8, 2003

In addition to notifying members of these changes in your March 8 letter to all members, you will need to ensure these changes are included in your EOC and that, if necessary, the changes are annotated in Section 3 of your SB.

- *Evidence of Coverage:* The model EOCs can be found at www.cms.hhs.gov/healthplans/marketing. These models have been updated as needed to include the changes in Medicare coverage. The changes are as follows:
    - PT/OT/SP Cap: The model EOCs did not mention this cap. If you address it in your EOC, be sure to remove the discussion in your EOC.
    - IVIG Coverage: In the Benefits Chart (Section 4) of the model EOCs, a new bullet has been added under "Drugs that are covered under Original Medicare."
    - RNHCI Coverage: Discussion of RNHCIs is included at the end of Section 7 of the model EOCs. The language has been modified to include this new provision.
- *Summary of Benefits:* The standard SB does not include any standard sentences that mention these benefits. However, if you have mentioned them in Section 3 of your SB (in particular, the therapy caps), please correct the information as needed.

THE EVIDENCE OF COVERAGE

The due date for sending EOCs to all members has been extended for all MA organizations and Medicare Cost Plans. All MA organizations and Medicare Cost Plans must send an EOC to all members no later than April 1, 2004.

The EOC is not a part of the streamlined marketing review process, i.e., the EOC must contain CMS-approved benefits. The EOC must also include the changes in Medicare coverage mentioned above.

If your EOC has already been approved by CMS but is not yet printed, then insert the new CMS-approved benefits and changes to Medicare coverage prior to going to print. You will need approval from CMS of the new benefits in the EOC. Simply highlight the changes you have made to your previously approved EOC in order to expedite the Region's review.

- If your EOC is with the CMS Regional Office and has not yet been approved, send change pages to the Regional Office so it may use them in its review of your EOC.

- If your EOC has been approved by CMS and is already printed, you may develop a CMS-approved errata sheet and send it to all members before the new EOC due date.

More information regarding the SB, PBP, and EOC can be found on CMS's web site. Questions concerning marketing materials should be directed to the appropriate Regional Office.

SECTION 10–"EXCLUSIVE" MEDICARE DISCOUNT CARDS AND MARKETING MATERIALS

Any MA organization or Medicare Cost Plan that will offer a Medicare-endorsed prescription drug discount card must not mention the offering in any marketing or other material until April 1, 2004. The MA organization or Medicare Cost Plan will be required to notify all members of the availability of this card. Notification must be mailed on April 1, 2004. A model letter is forthcoming. Prior to Group Enrolling, Exclusive Card Sponsors must notify all eligible members of its intent to enroll and their right not to enroll.

In addition to providing this notification to all members, Exclusive Card sponsors need to take the following steps with their EOCs and SBs:

- EOC: Any MA organization or Medicare Cost Plan that will offer a Medicare-endorsed prescription drug discount card must not mention the discount card in the EOC until April 1, 2004. Therefore, these MA organizations/Cost Plans must not mail the EOC to members until the April 1 deadline mentioned in Section 9. Model EOC language on the Medicare-endorsed prescription drug discount card is forthcoming.

- SB: MA organizations and Medicare Cost Plans must not mention their Medicare-endorsed prescription drug discount card in their SB until April 1, 2004. During the DIMA ACRP upload process in HPMS, users will be asked to respond to the two drug card questions below.

  HPMS will automatically generate the resulting SB sentences shown below for display in the HPMS reports and in the April 2004 release of Medicare Personal Plan Finder. MA organizations and Medicare Cost Plans must manually add these to the Outpatient Prescription Drugs category in Section 2 of their hardcopy SBs. The sentences must be placed at the end of the category, after all regular drug benefit sentences. Below are the HPMS questions and resulting SB sentences:

  1. Do you offer a Medicare-Approved Prescription Drug Discount Card program?
     - If yes - [MA plan name] offers a Medicare-Approved Prescription Drug Discount Card. Please contact the plan for additional information.

  2. Do you charge an annual enrollment fee to join the Medicare-Approved Prescription Discount Drug Card program? (If so, please provide the annual enrollment fee: ____ . See Section 7 for a discussion of the limits on the annual enrollment fee .)
     -If yes- [MA plan name] charges an annual enrollment fee of _____ to join the Medicare-Approved Prescription Drug Card program.

Please be aware that CMS provided some information regarding the ability of an organization to market its Medicare-endorsed prescription drug discount card along with the benefits in the MA/Medicare Cost Plans on page 69872of the preamble of the Interim Final Rule (IFR) that went on display in the Federal Register on December 10, 2004. The IFR can be accessed through http://cms.hhs.gov/discountdrugs/default.asp.

SECTION 11–SPECIALIZED PLANS FOR SPECIAL NEEDS INDIVIDUALS AND MEDICARE MEDICAL SAVINGS ACCOUNTS

Section 233 of the DIMA makes the Medicare Medical Savings Account (MSA) demonstration a permanent part of the Medicare Advantage program. MA organizations may begin offering MSA plans now. Any organization interested in offering such a plan must submit an application to CMS. Applications can be found at http://cms.hhs.gov/healthplans/applications/. The MSA portion of the application which had been included for the demonstration has been removed by CMS, but will be re-inserted shortly.

Section 231 of the DIMA allows MA organizations to begin offering plans that exclusively or disproportionately enroll "special needs" individuals, such as dual eligible individuals or individuals who are institutionalized. MA organizations may begin offering these plans now.

- Any organization currently offering a plan whose benefits are already tailored to a "special needs" population may immediately take advantage of this provision of the DIMA. To do so, the organization must contact CMS to indicate that it wants to implement Section 231 of the DIMA immediately. CMS will then re-classify the plan as a "special needs" plan, amend the organization's contract (if necessary), and notify the organization in writing when it approves the request to implement Section 231 of the DIMA. The organization may submit to its CMS Regional Office for review new plan marketing materials tailored specifically for the "special needs" population, but must not begin using those approved marketing materials until it receives the above-mentioned letter from CMS. The organization must retain any members who do not meet the plan's definition of "special needs" enrollees, but once it has received the above-mentioned letter from CMS, it may begin accepting only prospective enrollees who fit the plan's special needs eligibility requirements.

- Any current MA organization interested in offering a new "special needs" plan must submit its request to CMS Central Office with a copy to the appropriate CMS Regional Office. The Central Office Plan Manager and the Regional Office Plan Manager will review the submitted material and make a determination based on the information submitted as part of this proposal. The Central Office Plan Manager will inform the organization of the decision.

  When submitting a formal request, the organization must submit the following information as part of its proposal:

  1. Description of the proposed plan.
  2. Explanation of how the contracted provider network(s) will meet access and availability standards.
  3. Explanation of what types of providers will serve the plan(s) (e.g., Home Health).
  4. Proposed effective date for the new plan.

Once CMS has approved the new plan and its ACR and PBP, the organization may begin using CMS-approved marketing materials tailored specifically for the "special needs" population and accepting only prospective enrollees who fit the plan's special needs eligibility requirements.

SECTION 12–EXTENSION OF SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS TO REHABILITATION HOSPITALS, INPATIENT PSYCHIATRIC FACILITIES, AND LONG-TERM CARE HOSPITALS

Section 211(e) of the DIMA changes the financial responsibility of MA organizations related to individuals who are inpatients in rehabilitation hospitals, distinct part rehabilitation units and long term care hospitals on their date of enrollment in or disenrollment from an MA plan. Effective January 1, 2004, such individuals will be treated the same as individuals described in 42 CFR 422.264(a). In other words, MA enrollees who are inpatients in these facilities when they disenroll from an MA plan remain the financial responsibility of the MA organization until discharge. Similarly, individuals who are already inpatients in these facilities on their effective date of enrollment in an MA plan remain the financial responsibility of the original Medicare program through discharge. As with 1886(d)(1)(B) hospitals, the financial responsibility explained above is only for inpatient services.

ATTACHMENT 1–TRANSMITTAL FORM

Total Number of ACRs Attached: _____

Total Page Count for All ACRs: _____

MA Organization Information:

HCFA Contract #: **H-_____**

Organization Name:

Street Address:

City:

State:

Zip Code:

Primary Contact:

Name:

Title:

Phone Number:

Fax Number:

E-mail address:

Alternate Contact:

Name:

Title:

Phone Number:

Fax Number:

E-mail address:

Page Count for Each ACR:

ACR #1:	____	ACR #21:	____
ACR #2:	____	ACR #22:	____
ACR #3:	____	ACR #23:	____
ACR #4:	____	ACR #24:	____
ACR #5:	____	ACR #25:	____
ACR #6:	____	ACR #26:	____
ACR #7:	____	ACR #27:	____
ACR #8:	____	ACR #28:	____
ACR #9:	____	ACR #29:	____
ACR #10:	____	ACR #30:	____
ACR #11:	____	ACR #31:	____
ACR #12:	____	ACR #32:	____
ACR #13:	____	ACR #33:	____
ACR #14:	____	ACR #34:	____
ACR #15:	____	ACR #35:	____
ACR #16:	____	ACR #36:	____
ACR #17:	____	ACR #37:	____
ACR #18:	____	ACR #38:	____
ACR #19:	____	ACR #39:	____
ACR # 20:	____	ACR #40:	____

ATTACHMENT 2–MODEL LETTER TO CMS TO RETURN TO THE MA PROGRAM OR TO RE-ENTER A PREVIOUSLY REDUCED SERVICE AREA FOR CONTRACT YEAR 2003

Ms. Cynthia Moreno
c/o Ms. Rosanna Johnson
Health Plans Benefit Group
Center for Beneficiary Choices
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail stop: C4-23-07
Baltimore, MD 21244-1850

Subject: Notice of [insert plan name]'s intent to [insert whichever is appropriate: return to the MA program – or – re-enter a previously reduced service area] effective March 1, 2004 for contract number(s) [insert contract numbers]

Dear Ms. Moreno:

In accordance with Title II, Section 211 of the Medicare Prescription Drug, Improvement and Modernization Act, [insert organization name] is notifying CMS of its intent to [insert whichever is appropriate: return to the MA program – or – re-enter a previously reduced service area].

The counties to be restored to the contract are: [list counties]

[Optional] Our decision to reenter the above contract is based on the following reasons [list reasons].

If you have any questions, please contact [insert contact name] at [insert phone number and E-mail address].

Sincerely,

_____
[President/CEO], [Signature date]

[Insert address where CMS is to send contract activity information]

ATTACHMENT 3–CERTIFICATION OF NETWORK ADEQUACY

CERTIFICATION OF NETWORK ADEQUACY

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and [name of organization], hereafter referred to as the "MA organization," governing the operation of the following MedicareAdvantage contract(s): [insert contract number(s)], the MA organization has elected to [insert whichever is appropriate: return to the MA program – or – re-enter a previously reduced service area] beginning in March of 2004 and continuing through December 31, 2004 as permitted under Title II, Section 211 of the Medicare Prescription Drug, Improvement and Modernization Act. In doing so, the MA organization assures CMS that all Medicare-covered services, supplemental benefits, and additional benefits that members have contracted for in the service area are available and accessible pursuant to 42 CFR 422.112.

The MA organization has reported to CMS the current Health Service Delivery reports of providers/suppliers that may be validated by CMS. All information submitted to CMS in this report is accurate, complete, and truthful based on the best of our knowledge, information and belief.

_____
Signature

Print Name: _____
Title: _____
Date: _____

On behalf of:

_____
[name of MA organization]

ATTACHMENT 4–MODEL LETTER FROM MA ORGANIZATIONS THAT ARE RETURNING TO THE MA PROGRAM OR RE-ENTERING A PREVIOUSLY REDUCED SERVICE AREA

Date:

Dear <insert beneficiary's name>:

In October, [*name of MA Organization*] sent a letter telling you that after December 31, 2003, we would no longer offer [*name of MA plan*] in [*name of county(ies) and/or state*].

We are pleased to inform you that we will again offer [*name of MA plan*] in [*name of county(ies)]* beginning in March 2004. This is because a new law allows Medicare health plans that left the Medicare program to return for 2004.

Please read the enclosed 2004 Summary of Benefits that describes the plans and proposed benefits we will offer to people with Medicare in your area. All benefits begin March 1, 2004 and go through December 31, 2004. These benefits are pending Federal approval.

If you have already enrolled in a new Medicare Advantage plan and would like to stay enrolled in that plan, do nothing.

If you have changed to Original Medicare and bought a Medigap (Medicare Supplement Insurance) policy, please read the information attached to this letter. If you would like to discuss your choice with a trained counselor please call the *[insert specific State Health Insurance Assistance Program name]* at [*1-800-[XXX-XXXX] and [TTY number]*.

WHERE TO CALL FOR HELP - INFORMATION & ASSISTANCE

If you need more information about *[MA plan]*, please contact our Member Services Department at *[MA Organization's telephone number and TTY number*]. You may want to check with them to see if your doctors and hospitals are still part of *[MA plan]*'s network. Customer Service Representatives are available Monday through Friday *[X:XX a.m. to X:XX p.m.]*.

For general information or helpful booklets about Medicare, call 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov on the Web. TTY users should call 1-877-486-2048. For help comparing your Medicare health plan choices or choosing a Medigap insurance policy, call the *[insert specific State Health Insurance Assistance Program name]* at *[1-800-[XXX-XXXX]*. TTY users should call*[TTY number]*.

We sincerely regret any inconvenience and concerns these changes may have caused you. We look forward to serving those of you who decide to reenroll in *[name of MA Organization]*.

Sincerely,

[CEO or other official of MA Organization]

Attachment

Model Letter Attachment

What You Need to Know if You Have Applied For or Bought a Medigap Policy and Want to Reenroll in Your Medicare Advantage Plan

If you have applied for or bought a Medigap policy and you think you now might want to reenroll in [*name of MA Organization*], you should know that returning or canceling a Medigap policy can cost you money. Also, if you cancel your Medigap policy you may not be able to get it back. If you do decide to reenroll in [*name of MA organization]* you can keep your Medigap policy, but it may cost you a lot and you may get little benefit from it while you are enrolled in our Medicare Advantage plan. You can call [*State Health Insurance Assistance Program*] if you need help understanding your choices.

If your Medigap has not yet gone into effect:

Before a Medigap policy becomes effective, you can contact the Medigap company or its agent to withdraw the application and ask that the company return any premium payment you submitted with the application. If you do, you should receive a full refund and not lose any money.

The 30-Day Right to Return Period:

For the first 30 days your policy is in effect, you have a *Right to Return* the policy for a full premium refund, **as if the policy was never in effect**.

If you return the policy within 30 days, you will receive a full premium refund.

Caution: During the time you were covered by the Medigap policy, you were receiving your Medicare coverage through the Original Medicare Plan. If you received any Medicare covered health care services during that time, Medicare will pay for them, but you will be responsible for paying whatever Medicare does not cover, just as you would if you had never purchased a Medigap policy.

After the 30-Day Right to Return Period:

After the 30-day Right to Return period, you may cancel your Medigap policy. This means that the Medigap policy was in effect for the entire time between the effective date and the date you cancelled it. The policy will pay supplemental benefits for all covered services you received during that period, but federal law does not require *the Medigap company to return any premium it has received.* **You may lose any premium you have paid in advance**. A trained counselor with [*insert specific state Health Insurance assistance Program name*] will be able to tell you whether the law in your State would require the Medigap company to return any premium it has received if you cancel your policy after the 30-day period.

ATTACHMENT 5–MODEL LETTER FROM MA ORGANIZATIONS CURRENTLY PARTICIPATING IN THE MA PROGRAM

Date:

Dear <insert member's name>:

In October, [*name of MA organization]* sent a letter telling you about changes to your benefits and premiums under [*name of MA plan*] to be effective January 1, 2004.

A new law gives Medicare health plans the chance to change their premiums and benefits for 2004. We have chosen to make changes to our plan(s). These proposed changes are described [*below* or *in the attached document*]. All changes are effective March 1, 2004 and go through December 31, 2004. These changes are pending Federal approval.

[Note to MA organizations: Clearly describe all premium and/or benefit changes and any new benefits that will be offered by the plan beginning March 1, 2004. Also describe new benefits covered by Medicare in 2004 in this letter. These changes are described in Section 9 of these instructions.]

For general information and helpful booklets about Medicare, call 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov on the Web. TTY users should call 1-877-486-2048. For help comparing your Medicare health plan choices or choosing a supplemental (Medigap) insurance policy, contact the [*insert specific State Health Insurance Assistance Program name*] at 1-800-[*XXX-XXXX*] and [*TTY/TDD number*] or visit the www.medicare.gov website. If you need more information , please call our Member Services Department at [*MA Organization's telephone number and TTY number*]. Also, if you have recently disenrolled from [*name of MA* plan] but would like to stay in our plan, you can call the Member Services Department at the above phone number. Please check with us to make sure that your doctors and hospitals are still part of [*name of MA plan*]'s network. Customer Service Representatives are available Monday through Friday [*X:XX a.m. to X:XX p.m.*]

Sincerely,

[*CEO or other official of MA organization]*